Harvard Pilgrim Health Care

#7491

May 27, 2010

David Morales, Commissioner
Division of Health Care Finance and Policy
2 Boylston Street, 5th floor
Boston, MA 02116

Re: Proposed Regulations
114.5 CMR 21.00: Health Care Payer Claims Data Submission
114.5 CMR 22.00: Health Care Claims Data Release

Dear Commissioner Morales:

Harvard Pilgrim Health Care ("Harvard Pilgrim") appreciates this opportunity to comment on the following two proposed regulations: 114.5 CMR 21.00 Health Care Payer Claims Data Submission and 114.5 CMR 22.00 Health Care Claims Data Release. As a general comment, Harvard Pilgrim has long advocated for greater transparency of cost and quality information from the inception of Massachusetts health reform (Chapter 305) in 2006 to the present. We continue to be a strong supporter of providing meaningful information to consumers, employers, providers and state agencies that will help both private and public decision makers to make decisions that will contribute to a high quality and cost-effective health care system in Massachusetts. At the same time, we are aware of our responsibility to keep our administrative costs at a reasonable level to meet both state requirements and the expectations of our employer groups.

The remainder of this letter will address our more general concerns, first with the Claims Data Submission regulation, then with the Claims Data Release regulation. I also have attached a separate listing of technical questions on specific data elements that our IT staff has raised. Last week Harvard Pilgrim staff participated in a conference call with Assistant Commissioner Sue Kaufman, Paul Smith, Michael Blumenthal and other Division staff. We felt the meeting was productive and resulted in answering a number of technical questions that we had. We greatly appreciated the opportunity to discuss our concerns and raise questions with the Assistant Commissioner and her staff.

114.5 CMR 21.00 Health Care Payer Claims Data Submission
Effective Date of Regulations

The proposed Claims Data Submission regulation requires the first data submission to be submitted by October 15, 2010 and thereafter on the 15th of each month. The proposed regulation will require health plans to submit significantly more data than they do under the existing HCQCC requirements. Specifically, health plans will need to provide claims and eligibility data for self-insured accounts as well as two new files – a Product file and a Provider file. As a result, a large number of new fields and data elements must be developed, programmed and tested within a very short time frame. Given that a number of questions remain regarding what is meant by specific elements and given that IT resources are limited, an October 15th date does not appear to be feasible. We would

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recommend that the Division and the health plans work together to discuss any questions concerning new data reporting requirements and the feasibility of providing the requested information and to resolve any confusion plans may have about various new data elements. We would also recommend that the initial submission occur no earlier than 6 months after questions have been resolved to allow for a reasonable implementation period. We believe this approach will avoid later revisions or corrections that will take even more time and resources.

Size and Timing of Submissions:
As we noted in our conference call with Assistant Commissioner Kaufman and Division staff, the size of the submission using the existing SENDS+ software will greatly increase, given the addition of self-insured data. Even now, with the submission of only fully-insured data, encrypting and uploading files from Harvard Pilgrim PCs using the SENDS+ software takes a fair amount of time. This will increase with the addition of self-insured data. As discussed with the Division in our conference call, we would recommend that the Division ensure that the SENDS+ software system can handle the size of the increased files. If possible, a more automated method of encrypting and sending the files would be a major time-saver.

We also noted in our call with the Assistant Commissioner that the new due date for submitting monthly claims files by the 15th of the following month is earlier than the current requirement. This may cause a problem for at least some payers (including Harvard Pilgrim) depending upon their schedules for loading the latest data into data warehouses they may use. Not all the claims information associated with a particular month may be available. At least initially, there may appear to be a disparity in the data provided prior to the implementation of the new regulation and subsequent to its implementation.

Feasibility of Collecting Certain Data Items:
Based on our experience in the States of Maine, New Hampshire and Vermont, we have concerns about the feasibility of providing distinct data for servicing and billing providers. Because the payment of claims does not depend on whether a provider is the actual servicing provider, obtaining this information from providers has not been very successful. Moreover, under federal Department of Labor rules, we cannot deny payment of a claim on the basis that data elements are missing when those data elements are not required to pay the claim. This gives us little leverage over providers to submit information as to whether they were the actual servicing provider. We would recommend that thresholds for successful submission of this data be set at zero or at very low levels initially while the Division, which does have jurisdiction over providers, works with providers to have them submit this information.

Likewise, another issue is the inclusion of new data elements and fields in the Member files that would require us to provide data on deductibles, copayments, disease management programs, etc. While we understand the Division's desire to obtain information on all elements that may impact health care costs as well as programs that may improve quality, decrease utilization and decrease costs, in fact, much of this

information is not stored in a carrier's claims or eligibility system, but on separate stand-alone systems in different departments, making it difficult, if not impossible to link this information to specific member or account records. We'd recommend that the Division delay implementation of the Product file submission until January 1, 2012. During 2011, the Division and health plans could develop a more feasible method of obtaining information on cost-sharing variables (i.e., deductibles, copayments and coinsurance) that would not be member or account-specific, but would provide information on how many members are in plans that have a specified deductible range, coinsurance range and copayment levels. It should also be noted that the federal government, through its internet web portal, will be posting similar information by benefit plan design, although not member or account-specific. The Division may be able to utilize that information in lieu of another reporting requirement on health plans.

Penalties

The current Health Care Quality and Cost data collection regulations describe a specific penalty of $1,000 per week for each week of delayed submission or correction of data (following a two week grace period) up to a maximum penalty of $50,000 per year. The proposed regulation does not contain a specific penalty but instead references that the Division (after first sending notice to the payer that has failed to make necessary corrections or submissions) "...will take all necessary steps to enforce this provision to the fullest extent of the law." While Harvard Pilgrim has always tried to work cooperatively with the Division and will continue to do so, we are concerned that the regulation doesn't define a clearer process for working with the Division to make needed data corrections or to submit delayed data when system limitations make it impossible to meet a timeframe or a data threshold. We recommend that a distinction be made between failure to submit or correct data where the payer is failing to cooperate with the Division and failure to submit or correct data where the payer is cooperating with the Division but requires time to make the necessary changes.

Duplicate Data Requests from State Agencies and Harmonization with Other States

We understand that the Division's intention is that its database will become a central repository for payer claims data that other MA state agencies can use for their own data purposes. We support this goal and would urge that to the extent possible, other MA state agencies be required to use the Division's database rather than require payers to submit duplicative or nearly duplicative information to them. Harvard Pilgrim, like other payers, has experienced a dramatic increase in the number and types of data requests from state and federal agencies, requiring a greater allocation and expansion of IT resources to meet these various data submission requirements. This results in increased administrative expenses that are ultimately passed on to consumers.

Another issue of concern is harmonization of the data elements, fields and files with other states' claims databases. Currently, Harvard Pilgrim provides monthly or quarterly claims data feeds to Maine, New Hampshire and Vermont. While Massachusetts' data submission rules have closely followed those of the other states up to now, the proposed regulation does contain certain fields that now have data elements that no longer contain the same data as in the other states. We are concerned that we may need to spend an increasing number of resources in the future to maintain a Massachusetts data extract that

is separate and distinct from the extracts we prepare for the other states in which we operate. Moreover, as more states become interested in developing such claims data bases, the need to keep them as consistent and standardized as possible becomes all the more greater to avoid duplication of resources, increasing administrative costs and ensure their functionality for comparative research purposes.

114.5 CMR 22.00: Health Care Claims Data Release
Privacy and Confidentiality Concerns
Section 2.06 (Protection of Confidentiality) in the Health Care Quality and Cost Council's existing regulation on Uniform Reporting for Health Care Claims Data Sets (129 CMR 2.00) addresses the issue and requires that the HCQCC and any of its contracted parties comply with the provisions of M.G.L. c. 66A, the Fair Information Practices Act. To ensure the protection of confidential data, we suggest that the same language be added to the proposed regulation.

Data Release Committee
The regulation defines the Data Release Committee as a standing committee appointed by the Commissioner that will consist of Division staff members and members of the public with academic, technical, clinical, legal or statistical expertise. Harvard Pilgrim recommends that payers be represented on the Committee.

As noted at the beginning of this letter, we have comments or questions concerning a number of the requested data elements. Those comments are attached to this letter.

Thank you very much for your consideration of our comments. Again, we want to affirm our support for a database that will lead to greater transparency of information concerning costs and quality and will decrease administrative costs by reducing the number of duplicative requests for data.

Sincerely,

William J. Graham
Vice President, Policy and Government Affairs

Attachment

Attachment: HPHC Feedback on APCD Proposed Regulation

General Regulation Comments/Questions –

- Encryption – Is the intent to continue to use the SENDS+ process to send these files? We currently do the encryption directly into the values in the GIC files, but for HCQCC files, we use the SENDS+ software to do the encryption. The technical details of the file submission process are not outlined.
- Inclusion of self-insured data will vastly increase size of files. There is a need to ensure that the current method of submission using SENDS+ software can accommodate these larger files, or look into some more automated method.
- Clearer wording is needed regarding the inclusion of non-MA residents that belong to a MA based employer group. Providing examples may clarify this requirement.
- 21.03 (1) d. We are concerned about the open-ended language in this provision. Requests for additional information generally require a fair amount of lead time, given other demands on IT resources and the amount of time needed to program, enter and test any new data elements. We would recommend that changes to the data fields occur only on an annual or semi-annual basis and be scheduled. Schedule A 2. – Please specify if the 2 years of historical data should be in monthly files or in one large file. If it is one large file, alternate methods of submission other than SENDS+ should likely be explored for larger insurers.
- Schedule C 5. i. states that the Division wants monthly files based on claims incurred in prior month. Many incurred claims are not submitted for payment until 2-3 months after they are incurred. We recommend using claims paid in the prior month.
- Schedule C 5. ii. Similarly, we recommend using paid claims in the period noted, "..for the period of January 1, 2008 through December 31, 2009." As written, this provision is not specific enough and will result in different payers providing different information. Please define if these dates reflect the range of paid dates.

Data Submission Guide

1. Medical Claims Data Elements

- Both servicing and billing provider columns are included. This information is difficult to obtain, as our experience in ME, NH and VT has shown. This should be an optional, not a required, element until providers are required to submit this information by the State.
- MC055 Procedure code – Are homegrown codes allowed if a reference file is provided?
- MC079 – Product ID number – new item, used to link to product file. See issues raised under Product file section.
- MC080 – Not clear on what this is. Will this only be on adjustment lines? And depending upon the code set, there could be some issues in how different payers map their own explanation of payment codes to these values.

- MC094 – Patient Status Code: What values are expected here?
- MC095 – Other Insurance Amt: Medicare and COB are covered in other columns what is expected to be put in this column?
- MC098 – Allowed amount. Is this intended to be the contracted amount for the service line? Inclusive of third party payments or excluding those?
- MC107 - HCPCS code, how is this different from MC055, Procedure code?
- MC110 - Claim Process Date, how is this different from MC089 Paid Date?
- MC113 - Payment Arrangement Type: What are expected values? Free text or from a list of predetermined codes?
- MC114 - Excluded Expenses: How is this different from MC099 Non-covered amount?
- MC115, MC118, MC119 – These indicators may sound simple but could be complex or impossible to program.
- MC120, MC121 DRG Level and DRG Outlier: HPHC may not be able to populate these columns if our software does not assign these values.
- MC122 Pseudo Claim: How is this different than MC081 Capitation indicator?
- MC123, MC124 Denied Flag and Reason: What values expected for reasons? Payer defined values ok? Are claims denied for global payments considered denied for this flag? And is this a service line level assigned value or a value that should be the same on every line of the claim?
- MC126-MC129,MC131 Various Indicator columns, again, these are very time consuming to develop and many of these may not be possible given existing system limitations.

2. **Member Eligibility Data Elements**
   - ME031 need more detail of what values are expected.
   - ME041, ME042 Enrollment start date/end date – are these expected for the most recent plan year? Should they reflect the employer's plan year dates for folks continuously enrolled, or other dates for those joining later than open enrollment or terminating before end of plan year? This could be difficult depending on how different payers span their member data.
   - ME044 Member Age Group two comments: Need to specify date and what ranges the ages are, what would be put in this column
   - ME035-ME039: HPHC would not have this information
   - ME047 and ME048 Member PCP Effective and Termination Date: Unclear of intent of this field in this file. If the file has one record for every member that is active during the month, does the presence of this field indicate if a member changes a PCP during the month then we need to send two records? Will this be blank for those members if they kept the same PCP through the whole month?
   - ME050 Member Deductible Used : This is very difficult to get on a monthly file, it changes over the month as claims are paid, and we're talking about one record per month per member....so not sure how we'd determine what number to put here even if we could get it. This field is highly problematic. We recommend this field be eliminated.

- ME053 Disease Management Flag: Rosters for Disease management are handled on a different system. This could be very difficult for HPHC to get.
- ME054 Eligibility Determination Date: Not clear on what this is, need further definition or example. Is this related to Medicare eligibility?
- ME056 Last Activity Date: What is considered "activity"?
- ME063 Benefit Status: What values are expected here? Unclear what is wanted.
- ME071 Risk Pool Indicator: Is this a GIC assigned value? Unclear what is expected.
- ME076 Member Rating Category: What values are expected?
- ME081 Medicare Code: What values are expected?

3. Pharmacy Claims

- PC049- PC056 Prescribing physician plan number and demographics– this could be tricky for plans using PBMs to get, it would be dependent upon an accurate NPI number to link from the PBM's file to the payer's files, which may or may not work. The prescribing physician demographics has a similar issue, it is dependent upon whether there can be a link back to the payer's file from the PBM's. Some of these fields have 90% thresholds and there will likely be issues meeting this.
- PC060 Single/Multiple source indicator. Further definition needed on this.
- PC062 Billing Provider Tax ID #: Need further definition. The Pharmacy is the billing provider and their tax id is in PC019.

4. Dental Claims

- No comments made on Dental since HPHC does not have Dental products.

5. Product File

- As a general comment, we believe that the introduction of a product file to the database should be delayed until January 1, 2012 in order for the Division and health plans to come together and develop a file that contains data that is feasible to collect and well-defined. None of the other states in which we operate that have claims databases have a similar type of file, which probably speaks to the difficulty in producing one. Given that the federal web portal will be posting very specific benefit plan information by October 1, we would urge the Division to consider obtaining product-specific information from the federal web portal. If the Division does institute the Product file, then we recommend that it be updated on an annual or semi-annual basis.
- PR003 Product ID number – We are not sure what data elements from the provider file should be used to create a unique product id. We do not have unique product ids.
- Please see our comments in the text of our letter regarding our concerns with the product file concept. At a minimum, there needs to be an extensive definition of what one record in this file represents, with examples. Otherwise, different payers will be providing very different results for two products that are similar.
- Capitation is usually based on the providers not the product. We do not believe that capitation data should be in this file.

- If the pharmacy coverage is a rider, then it will be very difficult if not impossible to link that to the base medical product, especially for accounts where the employer group carves out pharmacy.
- Is this file all product combinations offered in MA or is it only the product combinations that groups that have MA resident members have.

6. **Provider File**
   - Inclusion of pharmacies is new and would come from a different source, our PBM, so this would require extensive IT resources to map a third source into this file.
   - PV032 Provider Network ID – not sure all payers have this data element. We do not believe HPHC does based on the description given for this column. Is this a GIC Provider file field? If so can that field be provided so we can map the correct information?
   - PV041 is this a specific field from the GIC Provider file? If so can that field be provided so we can map the correct information?